New Hampshire Case Report
Arboviral Infection
Encephalitis/Meningitis

This form must be faxed to the New Hampshire Communicable Disease Control Section (603-271-0545) *and* a copy submitted with the laboratory specimen(s) to the NH Public Health Laboratories

PATIENT INFORMATION

Name: _____ Date of Birth: ___/___/___ ☐Male ☐Female
Last First MI mm dd yy

Home Address: _____ Homeless ☐Yes ☐No
Street City State Zip

Phone (H)_____ (W)_____ (Cell)_____

RACE ☐White ☐Black/African American ☐Asian ☐Native Hawaiian/Pacific Islander ☐American Indian/Alaska Native ☐Unknown

ETHNICITY ☐Unknown ☐Hispanic ☐Non-Hispanic

CLINICAL INFORMATION

Current Diagnosis: ☐Encephalitis ☐Meningitis ☐Other_____

Hospitalized? ☐ Yes ☐ No If yes, Hospital: _____

Date of Admission: ___/___/___ Date of Discharge/Transfer: ___/___/___

Physician/Provider: _____ Phone: _____

SYMPTOMS: Date of first symptoms ___/___/___ Date of first *neurologic* symptoms ___/___/___

	YES	NO	UNK		YES	NO	UNK		YES	NO	UNK
Fever ≥100F	☐	☐	☐	Disorientation	☐	☐	☐	Rigidity	☐	☐	☐
Highest Temp.				Delirium	☐	☐	☐	Cranial Nerve			
(if known)	_____°F			Lethargy	☐	☐	☐	Palsy	☐	☐	☐
Headache	☐	☐	☐	Stupor	☐	☐	☐	Rash	☐	☐	☐
Stiff Neck	☐	☐	☐	Coma	☐	☐	☐	Location	_____		
Tremor	☐	☐	☐	Muscle				Convulsion	☐	☐	☐
Vomiting/Nausea	☐	☐	☐	Weakness	☐	☐	☐	Paralysis	☐	☐	☐
Confusion	☐	☐	☐	Hyperreflexia	☐	☐	☐	Hemorrhage	☐	☐	☐
Seizures	☐	☐	☐	Muscle Pain	☐	☐	☐	Joint Pain	☐	☐	☐

Other_____

OUTCOME ☐Recovered ☐Residual Symptoms ☐Died ☐Unknown If patient died, date of death ___/___/___

LABORATORY INFORMATION/TEST RESULTS (attach laboratory sheets)

Acute specimens (serum or CSF) must be collected within 3 to 10 days after onset of symptoms. Convalescent specimens should be collected 2-3 weeks after acute sample. If CSF is collected and submitted, please include serum sample.

CSF (specify units) Date ___/___/___ Abnormal? ☐Yes ☐No ☐Unknown Glu_____ Prot_____ RBC_____

WBC_____ Diff. Segs%_____ Lymphs%_____ Gram stain_____ Bacterial Culture_____

Fungal/Parasitic tests_____ Viral test results (Culture/Serology/PCR)_____

CBC (specify units) Date ___/___/___ WBC_____ Diff.Segs%_____ Lymphs%_____

MRI Date ___/___/___ Result_____

CT Date ___/___/___ Result_____

EMG Date ___/___/___ Result_____

ANTIVIRAL TREATMENT ☐Yes ☐No ☐Unk If Yes, list below. **Date Started**

_____ ___/___/___

REPORTED BY: _____ **DATE OF REPORT:** ___/___/___

Phone _____ Pager _____